

THE CHEMICAL MANUFACTURERS ASSOCIATION'S ENVIRONMENTAL ILLNESS BRIEFING PAPER

[1990 -- After reading this Briefing Paper, Karen Stevens called the Chemical Manufacturers Association [(703) 741-5000] and was told that CMA lobbies for approximately 175 member companies, and supports twenty full-time lobbyists in Washington, DC. Members pay dues based on a sliding scale, beginning at \$7,000 annually for small manufacturer with chemical sales of less than \$1 million per year. The CMA is in the process of establishing a Political Action Committee to enable contributions to the campaigns of political candidates. -- S. Molloy]

Executive Summary

Known variously by more than 20 names, among them, chemical hypersensitivity syndrome, total allergy syndrome and 20th century disease, "environmental illness" is a subject of controversy within the field of medicine and an object of considerable public attention. For many patients, environmental illness has become the explanation for a combination of symptoms for which they've found no other acceptable explanation.

According to a small group of clinicians from a medically unrecognized specialty called "clinical ecology" or "environmental medicine," millions of people in this country suffer from environmental illness. Practitioners of environmental medicine report that the medical cause of their patients' conditions is a depressed immune system. These clinicians attribute their patients' symptoms which typically include headaches, fatigue, depression, anxiety and digestive problems primarily to exposure to trace amounts of virtually all synthetic chemicals found in food, water, air, clothing and everyday surroundings. In short, environmental medicine specialists believe their patients are severely "allergic" to the world they live in to the extent that many of them cannot function in society.

There is no doubt that these patients are ill and deserving of compassion, understanding and expert medical care. However, nationally known experts in the fields of allergy, immunology and internal medicine say the assertion that environmental illness is a legitimate disease is unproven. Elaborate testing of the immune systems of these patients almost always indicates normal immune functions, and they rarely have increased infections.

And only rarely are their symptoms supported by physical findings or laboratory tests. In addition, review of both the methods of diagnosis and treatment used by environmental medicine specialists have shown no convincing evidence that their patients have unique, recognizable symptoms or that their treatment procedures are any more effective than placebo treatment.

Environmental illness patients generally lead troubled lives and have genuine problems in coping with family, work and life-style pressures. They often eagerly accept environmental illness as the explanation for their condition and undertake the costly life-style changes including moving to new environments and eliminating all synthetic agents from their homes that are part of treatment.

Despite unsubstantiated evidence, environmental medicine specialists and their patients persistently advocate that environmental illness exists. What they have failed to prove in the scientific arena, they are attempting to legitimize in the media, in the legislature, and in the courts. The important elements of human interest stories, human suffering, controversy, testimonials, and novelty, have provided natural stories for the media.

Legislative initiatives have so far failed to legitimize environmental illness, but it would not be difficult for legislators to misperceive the goals of environmental medicine as medically legitimate. And lawsuits, of which several are currently pending, could multiply.

The label of environmental illness is a misdiagnosis and condemns these patients to the life of an outcast with little hope of cure. It is essential that their described symptoms be taken seriously. These patients deserve the best medical evaluation and treatment consistent with established medical principles.

It is not the legitimacy of the patients that is in question, but the alleged environmental cause. Failure to recognize this critical difference can result in enormous costs to the patient, to industry and to society.

"Environmental Illness" Background "Environmental illness" has no single, accepted definition. However it may be described as a diagnosis that ascribes a broad range of common substances in the environment. Proponents allege that these symptoms are triggered particularly by contact with trace amounts of chemicals in our food, water, air and daily surroundings.

Symptoms are typically multiple, subjective and unsupported by physical findings or laboratory tests. Headaches, fatigue, depression, anxiety and digestive problems are some of the common initial complaints.

Those physicians who diagnose environmental illness call themselves "environmental medicine specialists." (Formerly they called themselves "clinical ecologists.") Environmental medicine is very controversial. There is no residency training in environmental medicine and the certifying board for its practitioners is not recognized by the American Board of Medical Specialties.

Furthermore, the American Academy of Allergy and Immunology, the California Medical Association and the American College of Physicians have taken the position that the tenets of environmental medicine are unproven (Refer to Appendix D).

Diagnosis and Treatment

Practitioners of environmental medicine generally diagnose environmental illness by performing "provocation testing," which consists of exposing subjects to various mixtures of test substances at progressively higher concentrations. The testing is variously done by inhalation, injection or placing the test solution under the patient's tongue. If any symptoms occur, the test is positive.

Subsequently, part of the subject's therapy consists of injection of the offending agents in lower concentrations. This "neutralization therapy" has no proven or even logical medical or scientific rationale to support it, according to the medical community. Provocation testing and symptom neutralization bear some superficial resemblance to skin testing for allergies and allergy shots for desensitization but are actually quite different. (Refer to section on Allergic Diseases, p. 9.) No reputable medical organization accepts provocation testing combined with neutralization therapy as having scientific meaning.

Independent "provocation testing" of environmental illness patients, for example, has resulted in equal numbers of positive tests from placebo solutions and from solutions of substances to which they allegedly were sensitive. [Terr, A. I., 1987. In *Allergy: Clinical Ecology. Insights in Allergy*. 2(5).]

Another part of an environmental illness patient's treatment is to avoid the common substances that purportedly make them ill. This could include living in environments totally free of modern

synthetic materials, such as rooms or trailers with metal or porcelain surfaces; elaborate air filtration; and diets free of all additives, preservatives, or contaminants. This approach obviously renders the individual unemployable.

In short, there is no consensus on the proper diagnosis, treatment or even existence of environmental illness as a single, proven medical condition. The hypotheses of environmental medicine practitioners are medically unproven and have been rejected by professional medical organizations. In addition, the treatments, which are extremely expensive, have not verifiably helped patients any more than placebo therapy would.

"Environmental Illness" Impacts

Environmental medicine specialists and other advocates are well organized and effective at representing environmental illness as a recognized medical condition affecting millions of people in this country. These advocates are working hard to legitimize environmental illness. Environmental illness already affects the patients who accept it as a legitimate disease. Should environmental illness advocates succeed in their efforts, it would also impact society and many industries.

For the patients, the unproven tests used to diagnose environmental illness may in fact lead to misdiagnosis of a true medical illness. Because environmental illness cannot be clearly diagnosed by clinical criteria, environmental illness specialists use the history of presumed environmental exposure as the basis for diagnosis.

This belief in itself can be psychologically crippling. Indeed, some patients view themselves in a hostile world, surrounded by chemicals that make them chronically ill and physicians who do not care. Often, their life becomes centered totally around their disease. Coping becomes stressful and living needs become costly as these individuals change their life-styles to avoid all chemicals. They are determined to consume only organic foods grown without insecticides, sprays and fertilizers.

They may use only items made of glass, porcelain, stainless steel and untreated animal or plant fabrics (cotton, linen, silk, wood and leather). Often, this results in social isolation, difficulty within the community and unemployability.

The primary impact on society would be the huge cost associated with the legitimization of environmental illness. Up to now, environmental illness and the associated testing and therapy have not been eligible for coverage under such programs as medical insurance plans, Social Security disability, Medicare and Workers' Compensation. But proponents of environmental illness are now trying to legislate the legitimacy of environmental illness.

Although they have not been successful, it would not be difficult for legislators to misperceive environmental illness as medically legitimate and fail to recognize the potentially enormous cost that could accrue. Environmental illness advocates believe they are entitled to a number of sources of financial support. Among them:

- monetary damage for increased illness resulting from exposure;
- monetary damages for existing fear of contracting future illness;
- disability benefits from private insurance policies and Social Security;

- reimbursement for medical costs;
- Workers' Compensation payments;
- a variety of workplace protections (from termination, demotion, pay cuts, etc.);
- rehabilitation services; and
- financial assistance for alteration of living space.

Environmental illness forces nearly succeeded in accomplishing their goal in Maryland in 1988. They proposed legislation and it came close to being passed before informed health professionals became aware of it and managed to transform a bill legitimizing the diagnosis of environmental illness into a resolution to study the issue. The resulting study basically called environmental illness an unresolved issue; however, further actions by the legislature in Maryland on this issue seem unlikely in the near future.

Proponents of environmental illness have drafted "fill-in-the-blank" model legislation in an attempt to accomplish their aims. Such legislation could pop up in any state at any time. A carbon copy measure in California passed, but Governor Deukmejian vetoed it after the California Medical Association intervened.

The impact, however, would not be restricted to the chemical industry. Commonly used chemicals are found everywhere, in the home, the workplace, outdoors, shopping malls, and even hospitals. Potentially affected industries include the textiles, clothing, lawn care products, household cleaners, dry cleaners, paints and solvents, perfumes, hair treatment products, plastics, paper and many other consumer goods industries.

There is also the threat of lawsuits. Litigants seeking redress for personal injury allegedly resulting from exposure to toxic substances are numerous now. Should environmental illness be recognized by legal or judicial decree, these suits would only multiply. Toxic torts create special problems for the defendant in the best of circumstances. It is scientifically impossible to ever prove a negative, the nonexistence of something.

Plaintiffs typically allege effects at very low exposure levels that are only known to be caused at much higher exposure levels. Often, only the presence of nearby chemicals, rather than true exposure, is documented. Or they allege that health effects were caused by substances not known to cause those effects.

Suits involving environmental illness are further complicated by the lack of a definition of environmental illness. In the eyes of environmental medicine practitioners and their patients, almost any symptom could be caused by exposure to almost anything. But most physicians do not agree with the environmental illness advocates. For example, Dr. Abba Terr, an immunologist at Stanford University Medical School, summarizes environmental illness in a chapter of a recent book reviewing multiple chemical hypersensitivity:

The concept of multiple chemical hypersensitivities as a disease entity in which the patient experiences numerous symptoms from numerous chemicals and foods caused by a disturbance of the immune system lacks a scientific foundation. Published reports of such cases are anecdotal and without proper controls. There is no convincing evidence for any immunologic abnormality in these cases. Diagnostic methods have been shown to be unreliable. Diagnosis, treatment and theoretical concepts underlying the purported disease are not consistent with current immunologic knowledge and theory. As defined and presented by its proponents, multiple

chemical hypersensitivities constitutes a belief and not a disease.

[Terr, A. I., 1987. Multiple Chemical Sensitivities: Immunologic Critique of Clinical Ecology Theories and Practices. In "Occupational Medicine State of the Art Reviews: Workers with Chemical Sensitivities", ed. M. R. Cullen, Vol. 2(4):693. Philadelphia, Hanley and Belfus.]

Supporting Material: Theories of Etiology

Proponents of "environmental illness" ascribe many symptoms to exposure to numerous common substances in the environment. Although these can include natural chemicals, more often the symptoms are attributed to low level chronic exposure to synthetic chemicals. Most recently, environmental illness proponents have postulated that exposure to such chemicals causes a malfunction of the immune system that results in sensitivities not only to the chemicals to which the patient has been exposed but also to chemicals he may encounter in the future.

In the eyes of its advocates, almost any symptom can be attributed to environmental illness. But laboratory tests on patients who believe they are suffering from environmental illness have shown normal or inconsistent results.

Some of the patients who believe they have environmental illness also have symptoms characteristic of psychosomatic illness. [Terr, A. I. 1986. Environmental Illness: A Clinical Review of 50 Cases. "Archives of Internal Medicine". 146:145- 149. Stewart, D. E. et. al. 1985. Psychiatric Assessment of Patients with "20th Century Disease" in "Canadian Medical Association Journal". 133:1001 - 1006.]

Others have a variety of symptoms that do not fit any known medical disease. These latter patients should be investigated further with well designed scientific studies rather than being stigmatized by unproven illness that might hinder further medical investigation.

Allergic Diseases Environmental illness advocates have borrowed much of their terminology from the fields of allergy and immunology. This can be very confusing since there are legitimate allergic diseases that are well accepted and documented by the medical profession.

Environmental illness advocates claim that sensitization to one chemical may cause a spreading phenomenon in which the patient becomes allergic to many chemicals. True allergies do not behave this way. If a patient is sensitized to one chemical, they are sensitized only to that chemical and perhaps to a few other chemicals that are structurally almost identical. New sensitizations must occur before the patient will react to different chemicals.

Documented allergic diseases are caused when an individual develops an exaggerated IgE response to environmental, drug or microbial antigens. IgE is an immunoglobulin protein that circulates in the blood and brings about allergic responses; other immunoglobulins are involved less frequently. Typically, allergies do not affect everyone exposed to the substance. Minute amounts of the offending agent may cause symptoms in a person who is sensitized or allergic to the substance. But not all chemicals are capable of causing allergies.

Allergic individuals characteristically give rapid responses in skin testing, have high sum IgE levels and often have increased blood and tissue concentrations of eosinophilic leukocytes; an eosinophilic leukocyte is a specific type of white blood cell.

Symptoms are subjective changes perceived and described by the patients while signs are objective physical findings observed by the physician. Allergic symptoms typically involve the skin, the respiratory tract or the gastrointestinal tract. The following statements are generally true:

Food allergies may cause vomiting, cramps and diarrhea. Skin reactions cause hives, which are large blisters or red, itchy rashes. Respiratory allergies are either of the hay fever type which involves the nose causing sneezing or nasal congestion, or the asthma type, which involves the lungs and the lower respiratory tract causing difficulty in breathing. A severe generalized allergic reaction known as anaphylactic shock may have symptoms of a drop in blood pressure and spasm of the larynx leading to shock and suffocation.

The location and type of symptoms most often depends on the type of contact with the agent to which the patient is sensitized. For example, contact with poison oak or with poison ivy usually involves the skin and results in a red, itchy rash with small blisters. Firefighters who are exposed to smoke from burning oak or ivy, however, inhale and ingest the smoke and may have symptoms in the lungs, nose and gastrointestinal tract as well. [Hood, L. E. ed. 1984, Immunology, 2d. ed. 460-462. California: Benjamin/Cummings.]

In contrast to environmental illness, the symptoms of allergic reactions are reproducible. Usually a person who is allergic to an agent has the same type of contact and the same symptoms on each subsequent contact.

Problems with Medical Testing

The specialty of immunology is one of the newest and most rapidly changing medical specialties. Laboratory tests used to measure a person's immune system function are also relatively new and still evolving. Some of the laboratory tests proponents of environmental illness use to support their position are well established in the medical repertoire. Other tests are new and not accepted by the general medical profession. A few, such as cytotoxic testing, have been declared invalid by federal agencies [Fed. Reg. Vol. 48, No. 162, August 19, 1983-Notices.] which will not reimburse for performance of these tests.

Environmental medicine specialists often do a large number of screening tests on their patients. Inevitably, one or two tests are abnormal. Individual laboratory results are often compared with ranges of numbers rather than one absolute number. By chance alone, five percent of people tested with no clinical disease will have either "abnormally" high or low laboratory values.

The more tests that are done, the more often the result will be abnormal, simply because of the mathematics involved. Proponents of environmental illness use these abnormal tests as proof that the patient has environmental illness.

The nonstandard test most often conducted by environmental medicine specialists is provocation with neutralization. In provocation testing, subjects are exposed to concentrations of suspected substances either by inhalation, injection under the skin, or placement under the tongue. The occurrence of any symptoms within a short period of time are noted; any symptom is interpreted as a positive test.

Lower concentrations are then given until no symptoms occur. The concentration resulting in no symptoms is termed the "neutralizing dose." Provocation testing is not an accepted practice within the medical community.

Any patient has the right to expect that a qualified person is managing the laboratory in which tests of immune function are being conducted. The patient also has the right to expect that the physician interpreting the test results is qualified. Both the American Board of Pathology and the American Board of Internal Medicine, in conjunction with the American Board of Pediatrics and the American Board of Allergy and Immunology, now have examinations to assess the competence of clinical pathologists, internists and pediatricians conducting diagnostic

immunologic tests.

"This certification process was developed to ensure that clinical immunology laboratories are directed by the persons who know the most about conducting such tests, properly applying them in diagnosis, and interpreting the results." [1988. Certification in Diagnostic Laboratory Immunology, "Annals of Internal Medicine". 108: 458-459.]

Why "Environmental Illness" is Not Science or Medicine "Environmental illness" lacks credible medical specificity. The symptoms, which are changes perceived by the patients, reported are neither substantiated by clinical signs, which are objective physical indications of illness, nor by laboratory testing of a wide array of body functions. The breadth of isolated symptoms is exceeded only by the number of purported chemical and environmental causes.

Indeed, there is no medical precedence to suggest that any syndrome or disease can be brought on by numerous separate and distinct agents.

Proponents of environmental illness assert that environmental illness exists because they have repeatedly observed patients with multiple, non specific symptoms, conceivably arising after a variety of exposures to numerous chemical substances. The heart of the problem lies in their reasoning process and the validity of the data they use to support a causal link.

The basic fallacy in their reasoning is that the observed symptoms may be induced by many other causes. An equivalent example of such erroneous reasoning is that if a rooster crows every morning before sunrise, then the sun rises because roosters crow.

Because a case of environmental illness cannot be defined objectively, control individuals (those without both the "disease" and exposure to the "agent") cannot be defined in order to perform traditional scientific studies. This fact is confirmed by the current scant medical literature on the subject, which only emphasizes collections of cases. Such case studies without controls cannot prove the valid existence of environmental illness but can only assert its existence.

Such hypotheses by environmental medicine practitioners are unfocused and scientifically unfounded, and have been rejected by main-stream professional medical organizations.

The data used by the proponents of environmental illness is largely invalid. [California Medical Association Scientific Board Task Force on Clinical Ecology. 1986. Clinical Ecology - A Critical Appraisal. "Western Journal of Medicine", 144:239-245.] Their principle data consists of uncontrolled and unblinded observations of alleged patients improving after therapy. Simply stated, they have not considered classical placebo effect, whereby a small percent of treated individuals will always improve regardless of whether effective therapy was used or not (the good effects of sugar tablets have been known for 2000 years).

Other problems with their information are that appropriate epidemiology cannot be applied, their patient history questionnaires are overly simplistic and biased, and high quality psychological testing of patients is generally avoided.

The scientific dilemma is that well conducted studies (with controls) cannot prove the nonexistence of the "disease" because true science can not prove a negative. Advocates can only assert the existence of a theoretical condition while assailing traditional clinicians and scientists for not having the ability to disprove their theory.

People who have received the label of environmental illness clearly merit the compassion and understanding of the medical and social communities. Emphasis should be placed on proper

psychological diagnosis and treatment rather than upon false labels and therapy that can ultimately prolong their impairment.

Because the role of true science is inherently limited, it is the responsibility of reputable scientists and clinicians to emphasize that environmental illness has not been proven to exist.

Responding to the Media

Because environmental illness is a health issue, its debate is best left primarily to physicians; the chemical industry, for example, should not get overly involved in such debates. Nonetheless, a ready response for media queries is a prudent precaution. Should reporters, editors, news directors or other media question industry about environmental illness, it would be appropriate to respond in a limited way. Steps best taken are:

- Monitor media coverage of the issue.
- Gather relevant background and reference material.
- Identify medical personnel familiar with environmental illness who can speak as experts.
- Informally offer guidance and background materials to reporters, based on their degree of knowledge.

Workers' Compensation Trends

Legislation already introduced by environmental illness support groups is designed to legitimize environmental illness for disability purposes. Given this thrust, more and more workers' compensation claims are expected. Presently, no state recognizes environmental illness on its list of workers' compensation diagnoses.

Each case would be considered on an individual basis. Since proponents of environmental illness advocate that patients suffering from environmental illness avoid all contact with synthetic chemicals, a diagnosis of active environmental illness could preclude return to work in many jobs.

Cost Impact

Once workers' compensation claims are settled, the plaintiff often files a toxic tort claim based on product liability theory. At the present time, it is estimated that to defend an average case of this type through a jury trial costs in excess of \$200,000 to \$300,000. No figures are available on the number of environmental illness cases filed nationwide.

Expert Testimony

Proof of causation varies greatly from jurisdiction to jurisdiction. For this reason it is impossible to give a short definition that would be accepted by most jurisdictions. However, in each case the plaintiff bears the burden of proof on the issue. Often the plaintiff needs a person accepted by the court as an expert who will testify that there is a cause and effect relationship to a reasonable degree of medical certainty.

The qualifications for being an expert vary from jurisdiction to jurisdiction and even from judge to judge, as does the meaning of "reasonable degree of medical certainty." While there have been

a few exceptions, in most cases environmental illness proponents have not been excluded from giving expert testimony.

State Legislative Summary: History of Legislative Initiatives in Environmental Illness

California: Legislative activity in California began with a bill (AB 3587) introduced in 1981 to primarily set up a "chemical hypersensitivity syndrome advisory committee." It also made provisions for educating those who believed they were environmentally ill about treatment and life-style changes, public education for prevention, and workshops to facilitate exchange between researchers and proponents of environmental illness. The bill passed in both Houses of the California Assembly but was vetoed by Governor Deukmejian.

A second bill (SB 1177) was introduced in 1985. It requested funding for a pilot project to identify those allegedly affected by this syndrome, to develop a clearinghouse for information and advocacy, to provide legal, financial, medical and support services and to conduct and coordinate interdisciplinary conference and research activities on environmental illness. This bill was also defeated.

Connecticut: A public health committee House bill (5191) was defeated in Connecticut in 1987. It would have established a program to study and treat environmental illness at the University of Connecticut Health Center in Farmington.

Maryland: The Maryland Senate drafted and both chambers passed Joint Resolution 32 (1988), which directed the Maryland Department of Environment to conduct a study on the alleged "chemical hypersensitivity syndrome." [Bascom, R., M.D., M.P.H. 1986. "Chemical Hypersensitivity Syndrome Study." University of Maryland School of Medicine.] While there is no single definition of environmental illness or the problems it is alleged to pose, the study group's mission was to determine if people could be classified as suffering from allergic reactions.

When the study was finished, Maryland's Secretary of the Department of Environment, Martin Walsh, sent an advisory letter to Governor William Donald Schaeffer. In his closing summary of the environmental illness study, Walsh dictated that "...a great deal more research is needed before there will even be a consensus on a definition of chemical hypersensitivity. It is, in my view, premature to classify environmental illness as a purely environmental problem in the classic sense." (Refer to Appendix E.)

A copy of the Maryland Department of Environment's Report on chemical hypersensitivity syndrome can be ordered from the Maryland Department of the Environment, 2500 Broening Highway, Baltimore, MD 21224 (Fee: \$25).

Florida: In 1989, Florida passed a bill creating a registry of people believing they have multiple chemical sensitivities. Creation of such a registry implies that the disease listed is accepted as proven. In this case, this is not true.

Because environmental illness lacks clear definition, the issue could be considered in various state legislative committees. Depending upon the intent of an environmental illness bill, it could be forwarded to Health and Welfare, Labor, Judicial, or Environmental committees. If the proposal focused on alleged allergic reactions, it would be considered by Health related committees; if the purpose of the bill were to review workers' compensation claims rising out of alleged environmental complications, it would be reviewed in Labor or Judicial committees; and, if the proposal asserts environmental concerns then the bill would be sent to Environmental committees.

Legislators and respective staff should be wary of legislation attempting to review and redress the issue of environmental illness or related themes. (The topic is not easily recognizable as it is not consistently addressed by the popular names of environmental illness or chemical hypersensitivity syndrome.) Environmental illness bills should be thoroughly critiqued by members of the medical and legal community prior to legislative action. When considering a bill, legislators should remember that environmental illness is a grey area, one which has not proven its existence in the medical arena and one which has no precedence in state statutes.

Legislative and Social Goals

Dr. Linda Lee Davidoff, representing the Environmental Illness Support Group, stated in her testimony to the Environmental Affairs Committee of the Maryland Senate, on May 8, 1988, that if Senate Joint Resolution 32, titled "Chemical Hypersensitivity Syndrome" was enacted, "chemically sensitive" people would benefit from:

- access to insurance coverage;
- social services;
- financial assistance;
- vocational rehabilitation; and
- alternate housing.

E.J. Davis, J.D., M.P.H., editor of "Ecological Illness Law Report", Vol. 2(6): p. 3, revealed several specific legal goals of his agenda, several of which follow:

- preventing "improper" employee dismissals and demotions;
- securing and maintaining a "safe" work environment;
- securing financial assistance for the rehabilitation of living space;
- securing coverage under Medicaid or Medicare and various state and federal assistance programs;
- securing workers' compensation payments;
- securing assistance under federal and state protections for disabled;
- securing compensation from companies and individuals responsible for chemical exposures that cause disabling illness;
- securing proper income tax deductions for expenses associated with ecological illness, especially excess costs of remodeling or changing heating systems and organic foods; and
- securing safe environments and food in prisons, mental hospitals, hospitals, and other public and private institutions.

Overlap With Indoor Air Pollution

Indoor air pollution or "tight building syndrome" is currently a major topic in several regulatory agencies and environmental advocacy groups. Symptoms often resemble those attributed to environmental illness. Among them: headaches, dizziness, drowsiness, nausea, irritations of the skin and upper respiratory tract, anxiety, irritability and other nervous system disorders.

Insufficient provision of fresh air in a building's heating, ventilation and air conditioning system, resulting in a buildup of air contaminants, formaldehyde, pesticides, cleaning materials and others, most often is cited as the cause. However, rarely is a specific agent indicated.

Environmental illness advocates would like society to believe that "sufferers" in indoor air pollution have a form of environmental illness because this would significantly increase the victim population and further legitimize their cause.

Forming Coalition

Because it has the potential to impact many segments of society, many groups have an interest in placing environmental illness in its proper perspective. Among them:

- medical associations;
- manufacturers and applicators of agricultural and pesticide products;
- Personnel, labor relations, etc.;
- food dealers;
- restaurants;
- insurance companies;
- self-insurers;
- soap and detergent manufacturers;
- chambers of commerce;
- lawncare services;
- homebuilders;
- aerospace industry;
- retailers; and
- automobile manufacturers.

Because environmental illness is a health issue, the only people who can legitimize it are physicians, and they have not. Should environmental illness arise as an issue, a coalition with the state medical association is absolutely necessary.

Appendix A

Synonyms for Environmental Illness

Allergic Toxemia, Cerebral Allergy, Chemical AIDS, Chemical Hypersensitivity Syndrome, Chemical Induced Immune Dysregulation, Complex Allergy, Ecological Illness, Environmental Hypersensitivity Disorder, Environmentally induced Illness, Immune System Dysregulation, Multiple Chemical Hypersensitivity, Total Allergy Syndrome, Twentieth Century Disease.

Appendix B

Environmental Illness Organizations American Academy of Environmental Medicine

The American Academy of Environmental Medicine (AAEM) was founded in 1965 as an international association of physicians interested in clinical aspects of environmental medicine. Prior to 1984, they were called the Society for Clinical Ecology (Environmental Medicine). This group changed its name after 1984. The position paper of the Society for Clinical Ecology states that the organization is made up of physicians, who are board certified in a clinical specialty and interested in newer concepts utilizing diagnostic and treatment modalities in treating environmental illness. The 1988 position statement of the AAEM is included in Appendix D of this paper. [AAEM, 10 E. Randolph St., New Hope, PA 18933 (215) 862-4544 or Fax (250) 862-2418]

American Board of Environmental Medicine, Inc.

Formal residency training is required for board certification. The board, however, is not recognized by the American Board of Medical Specialties, which is the umbrella organization overseeing specialty board certification of medical doctors in the United States. The American Board of Environmental Medicine, founded in 1988, offers its own examination in the field of environmental medicine. Executive director: Dr. Clifton R. Brooks, M.D., M.P.H., 2114 Martingale Dr., Noran, OK 73072; phone (405) 329-8437

Appendix C

Editorial Statement "Clinical Ecology: Environmental Medicine or Unsubstantiated Theory?" Reproduced with permission from the Annals of International Medicine, Kahn, Ephraim; Letz, Gideon, 1989 July; 11 1(2): 104-106).

Appendix D Position Statements: California Medical Association Scientific Task Force on Clinical Ecology, Clinical Ecology -- A Critical Appraisal [Information], reproduced with permission from the "Western Journal of Medicine", 1986 Feb.; 144:239-245)

American Academy of Allergy and Immunology (<http://www.aaaai.org/>)

American College of Physicians (<http://www.acponline.org/>) American Academy of Environmental Medicine

(<http://www.aaem.com/>)

For updated information, see CMA's Website (now known as The American Chemistry Council) <http://www.cmahq.com/>

About the American Chemistry Council and the US Chemical Industry "The American Chemistry Council is the voice of the US Chemical Industry. ..." " ... The business of chemistry is a \$460

billion enterprise and a key element of the nation's economy. ..."

<http://www.cmahq.com/About.nsf/open?OpenForm>

Chemical Manufacturers Association (CMA) Fact Sheets brought to you by EnviroSense

<http://es.epa.gov/techinfo/facts/cma/cma.html>

(Note: 3/6/2002 - this "position paper" no longer exists at EPA. The link now is a full blown special web site at the EPA for the chemical company's lobby to toot their own horn. How fair is this???)



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